MINUTES OF MEETING OF
HEALTH STRATEGIES COUNCIL
Department of Community Health, Division of Health Planning
2 Peachtree Street, 29th Floor Board Room, Atlanta 30303
Friday, February 17, 2006
■
11:00 am – 1:00 pm

Daniel W. Rahn, M.D., Chair, Presiding

MEMBERS PRESENT

Charles T. "Chuck" Adams
Elizabeth P. Brock
Tary Brown
Chris Bryson
W. Clay Campbell
Susan Chambers, RNC
Janet P. Deal
John F. Freihaut, DDS
Vernon E. "Trey" Googe, III
Michael E. Greene, MD
C. Thomas Hopkins, Jr., MD (via conference call)
Tamara "Tammy" L. King
Kirkland McGhee, JD
Lynn Mullis, DDS
Grace Groover Newsome, EdD, FNP
Gary G. Oetgen
James Peak
Kelly Penton
Louise Radloff
Sheila M. Ridley
Toby D. Sidman
Mark H. Wilson

MEMBERS ABSENT

Katie Foster
Venus Gines
Donna W. Hyland
Jessie L. Petrea

GUESTS PRESENT

Alison Land, Floyd Medical Center
Armando Bassarratte, Parker Hudson
Bill Lewis, Lewis Consulting
Brian Daughnil, Phears & Moldovan
Brian Looby, Medical Association of Georgia
Bryan Ginn, Medical College of Georgia
Courtney Merritt, Georgia Dental Association
Cynthia George, Phoebe Putney Health System

STAFF PRESENT

Neal Childers, JD
Charemon Grant, JD
Richard Greene, JD
Mathew Jarrard
Robert Rozier, JD
Rhathelia Stroud, JD
Stephanie Taylor

Dan Camprogi, GAHC
Dan Williams, DeKalb Medical Center
David Tatum, Children's Healthcare of Atlanta
Dayla Cervan, Sullivan Consulting
Dodie Putman, HSC-Georgia Division
Donald Palmisano, Medical Association of Georgia
Deb Bailey, Northeast Georgia Health System
Ed Bonn, Southern Regional Health System
Erin Moriaty, Atlanta Business Chronicle
Helen Sloat, Nelson Mullins
Holly Snow, Piedmont Hospital
J. Dwayne Colquitt, MD Piedmont Hospital/GSGS
Jimmy Lewis, HomeTown Health
Joe Parker, Georgia Hospital Association
John T. (Ted) Perry, Cartersville Surgical Associates
Joy White, Chafin Consulting Group
Judith Marone
Judy Adams, Georgia Assoc. Home Health Agencies
Julie Ballantine, Northside Hospital
Julie Windom, Georgia Alliance of Community Hospitals
Kathy Browning, Georgia Society General Surgeons
Kevin Rowley, St. Francis
Linda Womack, Emory
Lisa Jarvin
Lori Jenkins, Phoebe Putney
Marc Mullin, Gwinnett Health System
Marvin Noles, Medical Center of Central Georgia
Monty Veazey, Georgia Alliance of Community Hospitals
Price Corr, MD, Georgia Society of General Surgeons
Russ Williams, Hayslett Group
Scott Maxwell, Matthews & Maxwell, Inc.
Stan Jones, Nelson Mullins
Taffey Bisbee, Mitretek Healthcare
Tarry Hodges, St Joseph/Candler
Temple Sellers, Georgia Hospital Association
Tommy Chambless, Georgia Alliance Community Hospitals
Travis Lindsey, Resurgens Orthopedics
Victor Moldovan, Phears & Moldovan

WELCOME & EXECUTION OF OATH OF PUBLIC OFFICERS

Dr. Rahn welcomed Council members and guests and invited members to introduce themselves. He thanked members for their willingness to serve on this advisory body and executed the Oath of Public Officers to all new members who joined the Council subsequent to the November 2005 meeting.

OVERVIEW OF DEPARTMENT OF COMMUNITY HEALTH

Dr. Rahn called upon Neal Childers and Richard Greene to provide an orientation to Council members. Highlights of these presentations include the following:

Neal Childers reported that the Department of Community Health (DCH) was created in 1999. It represents a number of programs that had resided in separate agencies. The DCH is responsible for the administration several programs including:

- Medical Assistance Program (Medicaid)
- PeachCare for Kids Program
- Disproportionate Share Hospital Payments to hospitals in the state. These payments are provided to compensate hospitals for losses that are incurred as a result of treating uninsured patients.
- State Health Benefits Plan, which is a set of three health plans, established by the General Assembly, for groups of state employees including public school teachers, other employees of the public school systems and state government employees.
- Health planning and Certificate of Need functions for which the Health Strategies Council is the advisory body. The Council helps the DCH to set health policy and guidelines for the state.
- Health Initiative Programs, namely Commission for Men's Health, the Commission for Women's Health, the Office of Rural Health and the Office Minority Health.

He said that Rhonda Medows, MD serves as Commissioner of the Department. Dr. Medows was unable to attend today's meeting due to a prior commitment. Mr. Childers further noted that Jeff Anderson serves as Chair of the Department's nine-member board.

Mr. Childers noted that the Department's major purpose, as established by the legislature, is to serve as the lead planning agency for health issues in the state. The Department brings together a wide range of stakeholders including, the Department of Human Resources, hospitals, physician groups, and other provider groups to design and provide a coordinated and coherent mechanism for providing healthcare to all Georgians. He said that it is the intention of the state to maximize its purchasing power by having the greatest number of covered lives administered through a single agency. He said that such efficiencies of scale generate considerable savings for taxpayers. Mr. Childers reviewed the Department's mission and vision statements as follows:

> **Mission Statement**: The Department of Community Health is committed to improving the health of all Georgians through providing health benefits, systems development and education.
> **Vision Statement**: The Department of Community Health will be a national leader for innovative health planning, promotion, program and serves to improve community health.

INTRODUCTION TO THE DIVISION OF HEALTH PLANNING

Richard Greene introduced several members of the Division's staff including Stephanie Taylor, Senior Health Planner, Matthew Jarrard, MPA, Statistical Unit Chief, Mack Cawthon, Programmer, and Kimberly Anderson. He also provided an overview of materials contained in binders and specifically noted the Department's Ethics statement. He reminded Council member that they are required to read and sign this statement. Members were encouraged to contact Stephanie Taylor if there were specific questions about any administrative issues.

INTRODUCTION TO THE CON PROGRAM

Robert Rozier provided an overview of the CON Program (See Attachment A).
Questions were deferred until after the presentations by invited guest speakers.

ROLE OF COUNCIL & STANDING COMMITTEE INFORMATION

Dr. Rahn called upon Neal Childers to provide an overview of the role of the Council. Mr. Childers said that the Council is an advisory body that assists the Office of General Counsel, through its Health Planning & Certificate of Need Sections to define the policies and rules. He said that the Council very rarely functions as a committee of the whole, instead under the Bylaws; the Council is divided into three standing committees, namely Acute Care, Special & Other Services and Long Term Care Services. These standing committees meet annually. Their major function is to review the Certificate of Need Plans and Rules to determine whether changes are necessary. The standing committees report to the full Council. If the Council accepts the recommendations of the standing committees, technical advisory committees (TACs) would be formed. Members of the TACs are subject manner experts but also include Council members and a wide range of other statewide constituents. All meetings are open to the public. Rule changes are presented to the Board of Community Health for formal adoption.

STATUS OF TECHNICAL ADVISORY COMMITTEES

Dr. Rahn called upon Stephanie Taylor to provide an overview of the work of two technical advisory committees that are currently in place. Ms. Taylor noted that the Comprehensive Inpatient Physical Rehabilitation Services TAC has held approximately 6 meetings. They have expanded their scope of work to include both traumatic brain and spinal cord injury services. This committee is expected to conclude its work shortly and expects to present a review of its recommendations at the May meeting. Ms. Taylor also noted that the State Health Plan and Rules for Psychiatric & Substance Abuse Inpatient Services TAC Services has not been updated since 1990. She reported that the TAC held approximately three meetings and it is anticipated that there will be an additional two meetings before their work is completed. A report of their recommendations is also expected at the May meeting.

APPROVAL OF MINUTES OF NOVEMBER 18, 2006 MEETING

Dr. Rahn asked for a motion to approve the minutes of the November 18, 2005 meeting. A motion to accept the minutes was made by James Peak, seconded by Sheila Ridley. The meeting minutes were unanimously accepted and approved by the Council, as submitted.

LEGAL OVERVIEW OF AMBULATORY SURGICAL SERVICES RULES

Dr. Rahn stated that lots of concern has been expressed regarding the administration of the Department's current Ambulatory Surgical Services Rules and several issues have surfaced regarding the discipline of general surgery. He said that several organizations have requested the opportunity to present to the Council. Dr. Rahn asked Mr. Childers to provide an overview of the state's approach to ambulatory surgery services.

Mr. Childers provided an overview of Georgia's planning process for ambulatory surgery services and stated that the CON program in Georgia dates back to late 1970's. He said that there are some services that require the submission of a CON prior to development, while there are other services that are exempt from CON review. In Georgia, ambulatory surgery has been classified, by the General Assembly as a clinical health service, subject to CON review, since the inception of the CON program.

In 1984, the Health Strategies Council (HSC) and the predecessor agency, State Health Planning Agency (SHPA) adopted the first service-specific rule for ambulatory surgery services. At that time, the definition of general surgery was defined in the negative sense. It was defined as not being a limited-purpose category of service. The other type of service was a multi-specialty service. Not being limited purpose service, it was placed in a multi-specialty category.

In 1987, the SHPA amended that rule, which states that physician-owned office based surgery could be exempted from the numerical need methodology and adverse impact standards if it met a number of criteria (i.e. owned and operated by single-specialty physicians, did not have more than 2 operating rooms, appropriately accredited, adequate coverage for anesthesiology, demonstrated that charges would be lower than existing ambulatory surgery centers, and made 3% indigent & charity care commitment). This was an exemption from two criteria and was not an exemption from the CON program. These facilities were required to obtain a CON.

In 1991, the statute governing the CON program was amended by the General Assembly. They created a definition of a new type of health care facility called a Diagnostic and Treatment Rehabilitation Center (DTRC). Development of this service required a CON. One of the services that fell within the scope of DTRC was surgery, if it was performed in one of these centers. The General Assembly said that surgery that is performed in the offices of an individual private physician or a single-group practice of private physicians is exempt from receiving a CON if the surgery is performed in a facility that is owned, operated and utilized by those physicians, if those physicians are all of a single specialty and the capital expenditure to create this facility did not exceed one million dollars. The General Assembly later provided that this amount would be indexed for inflation.

The Rules of the SHPA were revised in 1994, but the agency did not change the definition of multi-specialty or single-specialty. The Rules continue to classify general surgery as not a single specialty.

In 1996, the SHPA created the Letter of NonReviewability (LNR) for physicians who proposed to establish office-based ambulatory surgery services. This document (LNR) provides confirmation to DHR/Office of Regulatory Services that this facility complied with the requirements of the CON statute and therefore the facility could be licensed as an ambulatory surgery center. Without the LNR, it is not possible to be licensed as an ambulatory surgery center. The Rule from 1996 is still in effect today.

Mr. Childers further said that in the interim, an ambulatory surgery TAC reviewed the service-specific Rules for ambulatory surgery services. Also, there has been litigation challenging the Department's Rule that defines general surgery, for the purpose of the CON exemption, as being a multi-specialty service. That litigation went before the Georgia Court of Appeals and they ruled that the General Assembly has prohibited the Department of Community Health from creating by rule, exemption for the CON program. Only the General Assembly, by statute, can create or expand an exemption from CON review. Furthermore, the Court of Appeals said that in reviewing the statutory exemption for single specialty office-based ambulatory surgery centers "the legislature did not intend to include general surgery as a single-specialty for limited purpose within the meaning of the single specialty exemption". Based upon that opinion, the attorney general, by law, the attorney for the executive branch of state government, which the DCH is apart, has formally advised the Department that the Department does not have the authority to make changes to these Rules.

PRESENTATIONS ON AMBULATORY SURGERY SERVICES

Dr. Rahn noted that invitations were extended to speak before the Council at today's meetings. Speakers represent the following organizations: Medical Association of Georgia, American College of Surgeons, Georgia Chapter, Georgia Society of General Surgery, Georgia Hospital Association, Georgia Alliance of Community Hospitals, and HomeTown Health. Each speaker was asked to limit his presentations to ten minutes. Questions were reserved until all speakers completed their presentations.

Department staff clarified that materials provided in member packets from members of the above organizations were additional emails and other written correspondence that were received by the Department and Dr. Rahn in advance of the today's meeting. Speaker handouts and testimonies were provided to Council members at the meeting and are posted on the Health Strategies Council's webpage.

Dr. Rahn said that the Council has asked the CON Commission to provide guidance about the role that the Health Strategies Council should play during the time that the Commission is examining the CON Program. He reported that the Commission indicated that it would like the Council to continue to carry out its responsibilities, as created in the enabling legislation.

The following comments and statements were made by Council members subsequent to the speaker presentations:

Dr. Greene – the role of the Council is to determine what should be done. The DCH Board will make some final recommendations and they should be aware of the Council's official statement on this issue. The Health Strategies Council is looking broadly at CON not general surgery, in specific. Georgia ranks 39th in the nation with regard to physician supply. Physicians take care of patients and not hospitals. Hospitals get indigent care dollars and physicians do not.

Charles Adams – This issue is best handled by the CON Commission.

Kirkland McGhee - There is a CON Commission that was established to examine this issue. It is their role to make recommendations about CON issues. The Council should not make such recommendations. Also, when the Attorney General issues an opinion to an agency, that decision is binding. It is unnecessarily political to place a burden on this Council to make such a decision. There are two policies

regarding CON. There are exceptions that seem to the swallowing the rules but the only people that have to live by the rules, by in large, are the hospitals. When we talk about containing healthcare costs, there is tremendous pressure by our system about how we access dollars. We do know that there are people who access the majority of their care through hospitals. We cannot take that safety net away from our society without some real thought. If we are studying this issue, as a state, it needs to be studied comprehensively by the CON Commission. We need to oppose any further discussion on this issue. Ambulatory surgery centers do not provide day-in, day-out support services for citizens. As a representative of the health insurance industry, I would have to agree that the important part of this issue is not only the lowered cost of the immediate care but to have facilities sustained over the long term. Insurance companies need hospitals to be there to provide a wide spectrum of care. We are in a position to study these issues. We have the Attorney General's opinion on this issue. The Council needs to be thoughtful and careful and slow about moving forward.

Vernon Googe- I think that Dr. Greene's point is important. The Council's charge is to make suggestions on matters of policy to the Board of DCH, who makes the Rules. There is no rational basis for differentiating general surgery from other classes of surgeons. The fact that the issue arises in the context of the broad review of CON is no reason for the Council to not go on record, as a policy, matter. Healthcare is moving towards more choice, more competition and more efficiency. To take a single class of surgeons and significantly restrict where they could work, while allowing other competitors to take advantage of such changes is fundamentally unfair. Most of the arguments that restrict general surgeons from providing the service apply to all other classes of surgeons that have been allowed to practice as a single specialty. The AG's legal opinion rests on an Appellate case. The opinion over-reaches. Fundamentally, that case was about whether the DCH Board had the authority, delegated by the legislature, to adopt rules. The Court said they do. Much of the information that was quoted to support the hospital's position is not central to the court's finding. Mr. Googe made the following motion:

> *The Health Strategies Council should vote to accept general surgery as a single specialty and should recommend that the Board of Community Health accept this recommendation. This motion was seconded by C. Thomas Hopkins, MD.*

Mr. Childers noted that the Health Strategies Council could make this recommendations but the Board of Community Health could not act on it.

Clay Campbell said that there are strong opinions on both sides. He said that the issue has more to do with Letters of Non-Reviewability than whether general surgery is a single specialty. Some people believe that there is no rational basis for any single specialty to be able to operate under a Letter of Non-Reviewability. The fact that the Commission has signed a resolution requesting that no action should be taken on CON at this time is enough to suggest that the Council should take no further action but should wait until the Commission has completed its work. He offered the following motion to the Council:

> *I offer a motion to table further discussion about this issue. This motion was seconded by Elizabeth Brock.*

The following discussion followed Mr. Campbell's motion to table further discussion:

Council member said that at the last meeting (in November 2005), the Council agreed that they would review data and information which was supplied to the Council by the Department. Members had agreed to vote on this issue at this meeting. Tabling further discussion until the CON Commission completes its work means that the Council would have to wait until after June 30, 2007 (the date that the Commission's report is due to the Governor and the General Assembly).

Council member noted that the CON Commission was established to provide input on CON issues. The Council needs to afford the Commission every opportunity to complete its work prior to taking any action on this matter.

Following this discussion the Council voted on the motion to table the discussion to recognize general surgery as a single specialty until the work of the CON Commission is completed. This motion was initially offered by Clay Campbell, seconded by Elizabeth Brock.

- ***Council members voting IN FAVOR of this motion to table discussion– 12***
- ***Council members voting IN OPPOSITION to the motion to table discussion – 9***

The motion to table further discussion on this issue passed.

Dr. Rahn thanked guest speakers for their presentations and noted that he would report the Council's deliberations to the CON Commission at their next meeting.

There being no further business, the meeting adjourned at 1:30 pm. Minutes taken on behalf of the chair by Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD
Chair

MINUTES OF MEETING OF
HEALTH STRATEGIES COUNCIL
Department of Community Health, Division of Health Planning
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APPENDIX A

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Introduction to Certificate of Need

Health Strategies Council
February 17, 2006

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Agenda

- What is Certificate of Need ("CON")
- Goals of CON
- Health Care Services that Require a CON
- How to Obtain a CON
- How is a CON Application Reviewed
- CON Exemptions
- Sanctions

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

What is CON

- Certificate of Need is the official determination that a new or expanded health care service or facility is needed in Georgia
- CON is one component of the State's overall health planning function established by Chapter 6 of Title 31 of the State Code
  - In Georgia, this health planning process has been in place since 1979

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Goals of CON

- To ensure that adequate health care services and facilities are:
  - Available to the citizens of the State;
  - Developed in an orderly and economical manner; and
  - Provided in a manner that avoids unnecessary duplication
- To ensure that only health care services that are found to be in the public interest are offered
- To ensure that health care services meet the various needs of the different regions of the State

O.C.G.A. § 31-6-1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Health Care Services that Require a CON

- Construction or development of a new health care facility
- Any expenditure by or on behalf of a health care facility in excess of $1.395 M
- Any increase in bed capacity of a health care facility
- Clinical health services which are not offered on a regular basis in or through a health care facility within the previous 12 months
- The purchase, lease, or use of diagnostic or therapeutic equipment with a value in excess of $775 K
- Radiation Therapy, Ambulatory Surgery, Biliary Lithotripsy, and Cardiac Cath offered in freestanding facilities

O.C.G.A. § 31-6-2(14)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Services that Require a CON: Clinical Health Services

- **Acute Care Related Services**
  - Short Stay Hospital Beds
  - Adult Cardiac Catheterization
  - Open Heart Surgery
  - Pediatric Cardiac Catheterization and Open Heart Surgery
  - Perinatal Services
  - Freestanding Birthing Centers
  - Psychiatric and Substance Abuse
- **Special and Other Health Services**
  - Ambulatory Surgery Centers
  - Positron Emission Tomography
  - Radiation Therapy Services
  - Magnetic Resonance Imaging
  - Computed Tomography
- **Long Term Care Services**
  - Skilled Nursing
  - Personal Care Home
  - Continuing Care Retirement Communities
  - Traumatic Brain Injury Facilities
  - Comprehensive Inpatient Physical Rehabilitation
  - Long Term Care Hospitals

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

How to obtain a CON

CON Application

- **Submitting an Application and Paying Filing Fees**
  - The amount of a filing fee is determined by the cost of a proposed project according to the following schedule:

    a) **$1,000 is the minimum filing fee** and covers projects costing zero to $1,000,000;

    b) one-tenth of one percent (0.001) for projects costing more than $1,000,000 with **no filing fee exceeding $50,000**

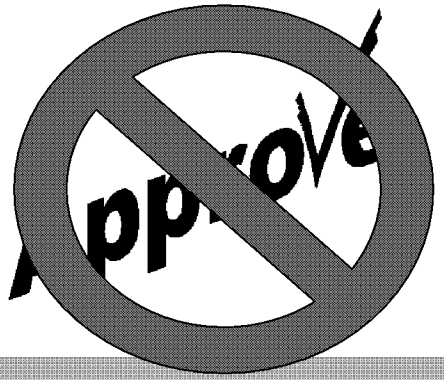
- **An application must be determined complete before substantive review of the application begins**

- **The review period is 90 days and may be extended an additional 30 days, if necessary. In no event shall a review exceed 120 days.**

How to obtain a CON

What Happens at the End of the Review Period?

– A project application, if not withdrawn, is either approved or denied by the Office of General Counsel. If the application is approved, an official Certificate of Need and project evaluation analysis is provided to the applicant. If the project is denied a denial letter and project evaluation analysis is provided to the applicant.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

How is a CON Application Reviewed: General Considerations

- The population residing in the health planning region has a need for services
- Existing alternatives to the proposed service are currently unavailable
- The proposed service is financially feasible
- The effects on health care payors are reasonable
- The construction costs are reasonable and adequate
- The service will be financially and physically accessible
- The proposed service will have a positive relationship to the existing health care delivery system

O.C.G.A. § 31-6-42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

How is a CON Application Reviewed: Service Specific Considerations

- Each clinical health service has a service specific rule which expounds upon the general considerations

- These service specific considerations must be addressed and satisfied in addition to the general considerations

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Services that Require a CON: Clinical Health Services

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

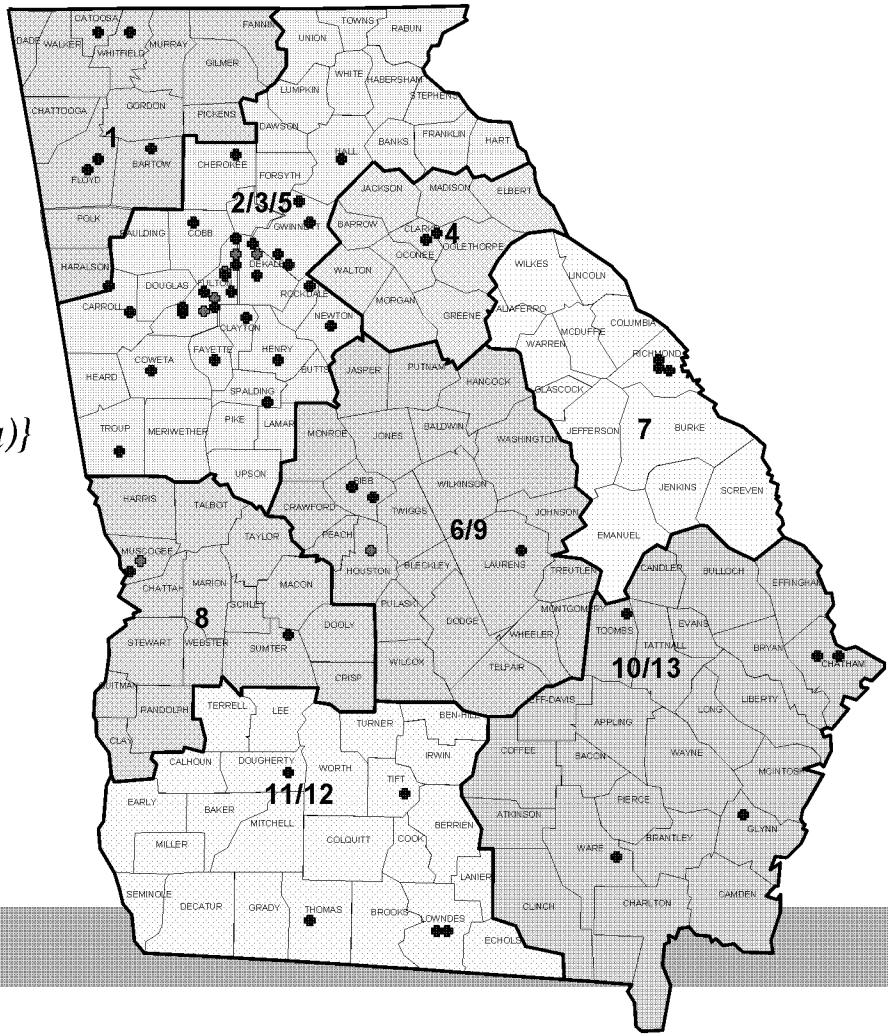
How is a CON Application Reviewed: Service Specific Considerations

Adult Cardiac Catheterization: ***Need***

- **Defined Health Planning Areas**
- **Population-Based Need Methodology**

$$< \lceil \{ [(\text{State Adult Caths} \div \text{State Adult Population}) \times \text{Projected Planning Area Population}] \times (1 + \%\ \text{of out-of-state caths performed in Planning Area}) \} \times \text{State-Wide Rate of Equivalents} \rfloor - (\text{Existing Inventory of Cath Labs} \times 1300) > = \text{Number of Cath Labs Needed}$$

- **Exceptions to Need**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

How is a CON Application Reviewed: Service Specific Considerations

Adult Cardiac Catheterization: *Existing Alternatives*

- Aggregate Utilization in Planning Area must equal 85% before additional services can be added

Adult Cardiac Catheterization: *Financial Feasibility*

- Document that at least 1,040 annual procedures will be performed within the first three years of operation
- Must have a cardiologist recruiting plan

How is a CON Application Reviewed: Service Specific Considerations

Adult Cardiac Catheterization: ***Effects on Payors***

- Proposed charges must be reasonable and comparable to other providers

Adult Cardiac Catheterization: ***Construction Costs***

- Must propose a plan to meet minimum physical facility requirements of the American College of Cardiology

How is a CON Application Reviewed: Service Specific Considerations

Adult Cardiac Catheterization: ***Financial Accessibility***

- Applicant must commit to provide at least 3% AGR in indigent and charity care services
- Applicant must provide policies relating to non-discriminatory treatment of patients

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

How is a CON Application Reviewed: Service Specific Considerations

Adult Cardiac Catheterization: ***Positive Relationship with Delivery System***

- Proposed service cannot result in the existing service providers' service volumes to decrease to less than 80% of capacity
- Must submit policies relating to continuity of care
- Must become JCAHO accredited

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Health Care Services that Require a CON

- Construction or development of a new health care facility
- Any expenditure by or on behalf of a health care facility in excess of $1.395 M
- Any increase in bed capacity of a health care facility
- Clinical health services which are not offered on a regular basis in or through a health care facility within the previous 12 months
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O.C.G.A. § 31-6-2(14)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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O.C.G.A. § 31-6-2(14)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CON Exemptions

- Physician Owned, Single Specialty, Office Based Ambulatory Surgery Centers established at a cost less than $1.515 M
- Equipment acquired at a cost of less than $775 K

- Replacement of CON-authorized equipment
- University Infirmaries
- Federal Health Care Facilities
- Business Infirmaries
- Offices of Private Physicians
- Acquisitions of existing CON-authorized facilities
- Expenditures to eliminate safety hazards or to comply with accreditation standards
- 10 percent increase in bed capacity if utilization has exceeded 85 percent for the previous 12 month period

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CON Exemptions: Ambulatory Surgery

1. Operating room environment
2. Performed in the offices
3. Individual private physician or single group practice of private physicians
4. Owned, operated, and utilized by such physicians
5. Of a single specialty
6. Does not exceed the amount of $1.515 M

Source: OCGA § 31-6-2(14)(G)(iii)

Georgia Department of Community Health

CON Exemptions: Ambulatory Surgery

Requirement: Operating Room Environment

- OCGA 31-6-2(16.1) and Department's regulations define "operating room environment"
  - Minimum physical plant standards of DHR

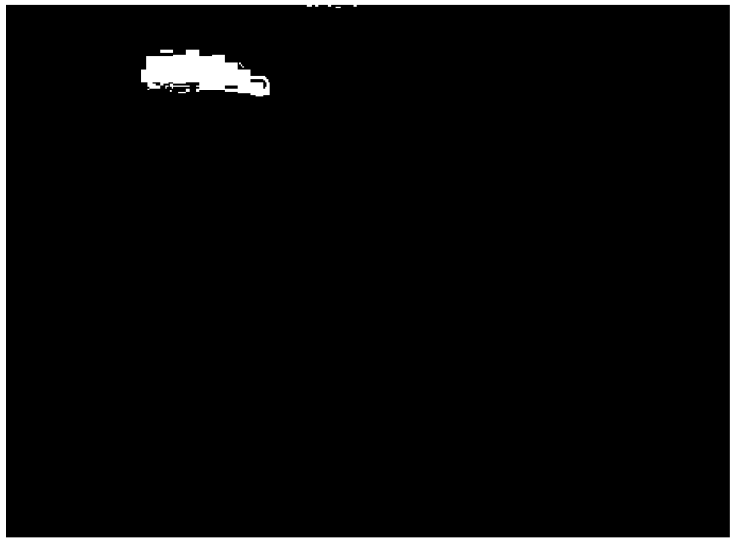
Source: Ga. Comp. R. & Regs. r. 272-2-.07(4)(g), (h), (j)

Georgia Department of Community Health

CON Exemptions: Ambulatory Surgery

Requirement: Office-Based

- Reasonable proximity to a clinical office space
  - Interpreted to mean in the same building as office space



Source: Ga. Comp. R. & Regs. R. & Regs. r. 272-2-.07(4)(f)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CON Exemptions: Ambulatory Surgery

Requirement: Individual Physician or Group Practice

- Evidence of Sole Physician Corporation or Group Practice, e.g. articles of incorporation, by-laws, operating agreements
- Affidavit stating that each physician belongs only to one practice

Source: Ga. Comp. R. & Regs. R. & Regs. r. 272-2-.07(4)(d), (l) - (

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CON Exemptions: Ambulatory Surgery

Requirement: Physician-Owned

- Must have at least 85% licensed physician ownership
- Ownership evidence must be submitted, e.g. stock certificates, operating agreement
- Must submit site entitlement documentation

[redacted]

Source: Ga. Comp. R. & Regs. r. 272-2-.07(4)(b)-(e)

Georgia Department of Community Health

CON Exemptions: Ambulatory Surgery

Requirement: Single Specialty

- All members and employed physicians must be of same surgical specialty
- Evidence generally includes an affidavit or documentation of specialty listed with Composite Medical Board

Source: Ga. Comp. R. & Regs. r. 272-2-.07(4)(b)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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Requirement: Single Specialty

- Neither Statute nor Regulations define "single specialty"
- Regulations define "multi-specialty"
  - Any ASC offering general surgery or any combination of general surgery and any number of the following specialties:

- Dentistry/oral surgery
- Gastroenterology
- OB/GYN
- Ophthalmology
- Podiatry
- Pulmonary Medicine
- Orthopedics
- Otolaryngology
- Pain Management/ Anesthesiology
- Plastic Surgery
- Urology

Source: Ga. Comp. R. & Regs. r. 111-2-2-.40(2)(j)

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Requirement: Does not Exceed $1.515 M

- Amount is adjusted annually for inflation in construction indices
- Includes all capital expenditures made by or on behalf of the physician or group in establishing and developing the ASC for the first three years including:
  - Construction
  - Equipment
  - Legal, consulting, and administrative fees
  - Interest during construction
  - Furnishings

Source: Ga. Comp. R. & Regs. r. 272-2-.07(4)(i), (k), (p), (q)

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CON Exemptions:
Diagnostic or Therapeutic Equipment

- Equipment that can be acquired for less than $775 K is exempt
- The dollar threshold includes associated costs such as construction, functionally related equipment, furnishings

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Differences between CON and LNR Processes

LNR

- No Need Analysis
- No Commitment to Indigent and Charity Care
- Limited to Statutory Restrictions
- No Review of Quality
- No Review of Fees
- No Requirement to Report Statistical Data

CON

- Calculated Need Must Exist
- Must Commit to Provide 3% of annual AGR to Indigent and Charity Care
- No limitations on ownership, location, cost, specialty, etc.
- Minimum quality standards must be met
- Fees must be Reasonable
- Must Report Annual Data

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Sanctions

What are the Sanctions for Failing to Comply with CON laws?

- DCH may issue cease and desist mandates and/or seek court injunctions to halt violations as well as impose maximum fines of $5,000 per day for every day a violation to the CON rules and regulations exists.

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Questions